MEDICAID QUALITY STRATEGY

The Center for Medicaid and State Operations defines quality as – The right care for every person every time. The Division of Quality, Evaluation, and Health Outcomes is responsible for supporting State Medicaid and SCHIP programs in their efforts to achieve safe, effective, efficient, patient-centered, timely and equitable care. CMSO will partner with States to share best practices, provide technical assistance to improve performance measurement, evaluate current improvement efforts to inform future activities, collaborate with quality partners and coordinate Center activities to ensure efficiency of operations.

CMS recently released a Medicaid/SCHIP Quality Strategy. http://www.cms.hhs.gov/medicaid/medicaid_qs.pdf Key strategies include: (1) Evidenced-Based Care and Quality Measurement (2) Pay-for-Performance (3) Health Information Technology (4) Partnerships (5) Information Dissemination, Technical Assistance, and sharing of best practices.

Evidenced-Based Care and Quality Measurement

CMSO supports States in their efforts to improve performance measurement and ultimately the quality of care through the use of evidence-based measure sets that have wide acceptability in the healthcare industry.

Pay-for-Performance/Quality (P4P)

P4P is a quality improvement and reimbursement methodology aimed at changing the current payment structure which primarily reimburses based on the number of services provided regardless of outcome. P4P attempts to introduce market forces and competition to promote payment for quality, access, efficiency, and successful outcomes. CMSO supports States in their efforts to implement P4P programs.

Health Information Technology (HIT)

HHS currently has a 10-year plan to transform the delivery of health care by building a new health information infrastructure, including electronic health records and a new network to link health records nationwide. CMSO encourages States to explore creative uses of HIT in their Medicaid and SCHIP Programs.

Information Dissemination and Technical Assistance

Information dissemination, knowledge transfer, and technical assistance is extremely important in the Medicaid and SCHIP programs given that States enjoy wide flexibility in program implementation. CMSO facilitates the sharing of model practices, lessons learned and innovative approaches to emerging issues through issues briefs, analysis of

demonstration evaluations, participating in conferences and Web casts and other methods.

For additional information, see:

http://www.cms.hhs.gov/medicaid/

http://www.cms.hhs.gov/quality/

http://www.cms.hhs.gov/researchers/

http://www.cms.hhs.gov/contacts/

http://www.hospitalcompare.hhs.gov/

http://www.medicare.gov/nhcompare

www.hhs.gov

www.whitehouse.gov

http://www.jcaho.org/

http://www.ahrq.gov/

http://www.ncqa.org/

http://www.nashp.org/

http://www.qualityforum.org/

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

Value-Based…Results-Driven…Healthcare:

The Medicaid/SCHIP Quality Initiative

August 2005

The Center for Medicaid and State Operations (CMSO) is committed to supporting State Medicaid and State Children's Health Insurance Programs (SCHIP) in their efforts to achieve safe, effective, efficient, patient-centered, timely and equitable care. The CMSO will work in partnership to achieve these goals, recommended by the Institute of Medicine, by engaging States, providers, consumers, and others in implementing evidence-based care, rewarding quality performance, controlling costs, and promoting the use of information technology. The vision, as noted in the CMS Quality Improvement Roadmap, is the right care for every person every time.

States administering Medicaid and SCHIP are challenged to provide quality services to an expanding population within budget constraints. Increasingly, federal and State governments, health care professionals, and insurers are exploring reforms in the current payment systems which typically focuses reimbursement on the number of services and procedures provided, rather than the quality and value delivered. Demand continues to grow for Federal leadership in these critical and complex areas of health care reform.

As one of the largest payers of healthcare in the United States, CMS has an important role to play in supporting States in their efforts to implement quality improvement strategies including pay-for-performance (P4P) programs, care coordination, patient safety initiatives, e-prescribing, electronic medical records, public reporting, evidence-based guidelines and performance measurement. States are eager to explore these innovative programs and have in fact led the way in many instances.

For example:

Indiana recently submitted an amendment to its State Plan to enhance the delivery of child health through the Indiana Health Information Exchange, a collaboration of Indiana health care institutions. The collaborative was formed for the purpose of using information technology and shared clinical information to improve the quality, safety, and efficiency of health care to children in Medicaid and SCHIP.

California, Michigan and New York have implemented Performance Based Auto-Assignment Programs that rewards health plans with superior performance. The programs create an incentive to improve Medicaid quality and preserve the safety net by increasing enrollee volume and payment to those plans that provide a consistent level of quality improvement.

Louisiana is currently planning to expand a Disease Management Outcomes Measurement System that utilizes nationally recognized performance measures to improve outcomes in diabetes, asthma and cancer screening. The expansion will promote improvement in the delivery system design, clinical information systems, patient self-management, and electronic decision support tools for practitioners.

Arizona recently developed a position paper that clearly articulates a need for the federal government to provide incentives to State Medicaid programs to develop methods of reducing medical error and improving quality measurement by exploring the development of models for P4P programs and electronic health networks.

CMSO will utilize a number of available avenues to assist States in their efforts to improve quality of care and reduce cost. The newly created Division of Quality, Evaluation and Health Outcomes will provide technical assistance to States as they seek to advance quality improvement activities. CMSO also will strengthen the quality focus in its guidance for waiver applications, State quality strategies, external quality review activities and State plan amendments.

Quality Strategy

CMSO is an integral part of CMS and as such, participated in the development of the agency-wide CMS Quality Improvement Roadmap. The five strategic components of the plan served as the foundation for the CMSO quality strategy. The CMSO quality strategy was modified to acknowledge the unique relationship between the federal government and States. Consistent with the philosophy of continuous improvement, CMSO attempts to avoid punitive and costly mandates but instead strives to encourage States participation in activities proven to improve the lives of beneficiaries.

CMSO recognizes the purchasing power held by federal and State governments and will join the national efforts to promote innovative approaches to transforming the delivery of health care. This transformation strategy requires CMSO to serve as a convener, change agent, and knowledge transfer organization. The basic elements of the plan include:

- Evidenced-Based Care and Quality Measurement
- Pay-for-Performance
- Health Information Technology
- Partnerships
- Information Dissemination and Technical Assistance

Evidenced-Based Care and Quality Measurement

CMSO will work with States to improve performance measurement and ultimately the quality of care. The need for consistency in performance measurement is becoming more

evident as the demand for data continues to increase. Payers and providers are finding it nearly impossible to fulfill the multiple requests for data, all of which have different data requirements unique to the individual payer. Federal and State governments, accreditation bodies, insurers, and health care professionals have now joined together to come to consensus on common evidence-based measure sets that have wide acceptability in the healthcare industry.

A voluntary consensus approach to measures development ensures that States will be able to maintain flexibility in measure selection while benefiting from having a menu of nationally recognized validated and tested measures from which to choose. Additionally, by using common measures, States can minimize the need to overhaul their information technology systems because they may be able to take advantage of existing databases such as those available through QualityNet Exchange, a secured communications site for data exchange.

Many States have already adopted the use of nationally recognized performance measures and utilize them in a number of areas including incentive programs, public reporting of quality, and in the development of policy reports. Maryland, Massachusetts, Minnesota, Ohio, Utah, and Wisconsin are a few of the States that collect standardized measures. All of these States conduct internal quality improvement activities and report quality results publicly on their Web sites.

Many other opportunities are available for States to conduct data mining of existing systems. CMSO will help States explore opportunities to develop genetic-algorithm-driven data mining programs for such system as the MMIS databases or the MSIS database. Multiple opportunities may also exist to help States develop initiatives to influence pharmacy benefits through data mining of pharmaceutical databases. The data will be useful when making decisions on formularies, adoption of formularies from private health plans, and development of joint formularies.

National databases such as those used to generate the National Nursing Home Compare data also provide States with a readily available source of information upon which to make decisions related to quality of care. Additionally, CMS has built improved infrastructure for the survey and certification system, such as a new complaint tracking and management information system, to identify and track needed improvement in quality. Significant investments also have been made in reporting and tracking such quality measures as the prevalence of pressure ulcers, incontinence, and physical restraints.

CMSO can play an important role in promoting measures of quality for which there is broad clinical acceptance. For example, CMSO, working with the Office of Clinical Standards and Quality (OCSQ), will advance a project to improve quality of care for neonates. By sharing information about successful health outcomes and cost savings, other States will be encouraged to undertake similar programs customized to their unique needs and resources.

Examples of measurable project goals include:

- Increasing the use of antenatal corticosteroids in pregnant women who are at risk for preterm delivery (reduces the risk of death, respiratory distress syndrome, and intraventricular hemorrhage); and
- Increasing the use of prophylactic surfactant administration in eligible neonates (reduces the risk of pneumothorax, pulmonary emphysema, and mortality).

The above guidelines are well accepted and the potential for improved quality and cost reduction is great. The March of Dimes estimates that $13.6 billion is spent on care for premature infants with nearly half of this cost or $6.8 billion paid by Medicaid programs. NIH estimates savings of $3000.00 per neonate treated with corticosteroids alone. Further, NIH notes that only 15% or eligible neonates receive the recommended therapy. If the percentage were increased to 60%, a conservative estimate of the annual savings in health care cost would be $157 million from the initial hospitalization alone.

Based on prevalence, health care expenditure and ability to make a positive impact through evidence-based approaches, CMSO, in partnership with States, will develop additional quality improvement program options.

Pay-for-Performance/Quality (P4P)

P4P is a quality improvement and reimbursement methodology aimed at changing the current payment structure which primarily reimburses based on the number of services provided regardless of outcome. P4P attempts to introduce market forces and competition to promote payment for quality, access, efficiency, and successful outcomes.

P4P is in its early stages of development and a great deal of work still must be done to determine the best method of approaching a comprehensive program. Several different models exist for P4P including extensive disease management programs. One demonstration currently in progress includes the Disease Management Demonstration for Chronically Ill Dual Eligible Beneficiaries. Under this demonstration, disease management services are being provided to dually eligible beneficiaries in Florida. LifeMasters, the demonstration organization, is being paid a fixed monthly amount per beneficiary and is at risk for 100% of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and LifeMasters.

CMSO will provide technical assistance to those States that voluntarily elect to implement P4P programs. Additionally, CMSO will convene States for a conference designed to explore methods of propelling P4P programs. Efforts will be geared toward promoting the following important concepts in P4P:

Overarching Principles: P4P programs must be:

- Data driven
- Beneficiary-centered
- Transparent
- Developed through partnerships
- Administratively flexible

Quality Components: P4P programs should be built on:

- Evidence-based guidelines
- Consistent measures of access, quality, costs, and satisfaction
- Coordinated care programs
- Health information technology

Incentive Structure: P4P incentives must be:

- Equitable and fair to program participants including the beneficiary
- Timely
- Sufficient to motivate improvement
- Flexible enough to provide payment for innovative care processes
- Structured to avoid unintended consequences

Health Information Technology (HIT)

HHS currently has a 10-year plan to transform the delivery of health care by building a new health information infrastructure, including electronic health records and a new network to link health records nationwide. The plan lays out the broad steps needed to achieve always-current, always-available electronic health records (EHR) for all Americans. National HIT activities are currently coordinated through the Office of the National Coordinator for Health Information Technology (ONCHIT). EHR systems will enable physicians and other health professionals to electronically tap into a wealth of treatment information as they care for patients and improve quality and patient safety.

Many States have embraced advancements in HIT. For example New York recently announced its Federal-State Health Reform Partnership (F-SHRP) with a plan to reinvest $1.5 billion of federal fund savings that were achieved under New York's section 1115 waiver. One component of the plan includes investing in health IT, including e-prescribing, electronic medical records, and regional health information organizations.

CMSO will join the CMS Quality Council Health Information Technology Workgroup in developing plans that will serve as models for States. The newly created Division of Quality, Evaluations and Health Outcomes has been charged with compiling information for States and providing technical assistance as they move forward with HIT activities.

Partnerships

Partnerships are essential to accomplishing the work ahead. The collective efforts of partners interested in true reform will have a great yield. Following are only a few examples of required partnerships:

- National Association of State Medicaid Directors (NASMD) - CMSO is working with NASMD to further refine a quality strategy and determine areas of collaboration. Formal communications channels for quality activities will also be established to facilitate the dissemination of information.

- Agency for Healthcare Research and Quality (AHRQ) - The Medicaid/SCHIP Quality Workgroup is currently collaborating with AHRQ on the next publication of the National Healthcare Quality Report. This report has been in existence for two years and, for the first time, CMSO will explore the publication of a section specific to Medicaid quality. Additionally, the workgroup is collaborating with AHRQ on a Care Management Knowledge Transfer Project.

- Center for Health Care Strategies (CHCS) – CMSO will work with CHCS in their efforts to provide training and technical assistance to help States, health plans, and consumer organizations effectively use managed care to improve the quality of services for beneficiaries, reduce racial and ethnic health disparities, and increase community options for people with disabilities.

- National Quality Forum (NQF) - The National Quality Forum currently has an informal workgroup established to explore pediatric quality of care measures. CMSO will begin a dialogue with NQF on potential measures of interest to Medicaid.

- American Health Quality Association (AHQA) – AHQA, the trade association for Quality Improvement Organizations (QIOs), has expressed an interest in working with States, CMSO and OCSQ to convert the current QIO/QIO-like review of quality and access in Medicaid fee-for-service and managed care into more meaningful quality improvement work for mothers, children, and the dually enrolled population.

- National Committee on Quality Assurance (NCQA) - NCQA continually addresses strategies and specifications for performance measures. Many of the measures that will be discussed over the next several months include attention deficit hyperactivity disorder (ADHD), diabetes, dental care, and asthma.

- American Academy of Pediatrics (AAP) - AAP has expressed strong support for improving the quality of care in the Medicaid/SCHIP population by exploring valid measures of quality and appropriate incentives for quality care. CMSO will continue to foster a collaborative relationship with AAP.

- National Association of Children's Hospitals and Related Institutions (NACHRI) - NACHRI has begun a dialogue with the CMSO to encourage improved pediatric performance measurement, national demonstrations, value based purchasing and other areas of importance in quality. CMSO will work with NACHRI to further develop these ideas.

- Internal Partners - The Medicaid/SCHIP Quality Workgroup and its subgroups will provide a formal structure for advancing quality efforts related to these programs. CMS regional offices will play a special role in information collection, analysis, information dissemination and technical assistance. CMSO has also begun dialogue with internal CMS partners on such projects as HCAHPS (hospital experience of care), the Surgical Complication Interventions Project (SCIP), the Ambulatory Care project and others.

Information Dissemination and Technical Assistance

Information dissemination, knowledge transfer, and technical assistance is extremely important in the Medicaid and SCHIP programs given that States enjoy wide flexibility in program implementation. CMSO will facilitate the sharing of model practices, lessons learned and innovative approaches to emerging issues through issues briefs, analysis of demonstration evaluations, development of a quality Web site, participating in conferences and Web casts and other methods. The Medicaid/SCHIP Quality Workgroup will develop and implement a formal communications strategy to ensure successful dissemination of information.

Moving Forward with All Deliberate Speed

The Medicaid and SCHIP programs are experiencing an unprecedented number of demonstration requests and State plan amendments that are focused on value based, results-driven approaches to providing health care to an expanded number of citizens. Professional organizations, providers, and consumers have growing expectations for Federal leadership in ensuring quality services within the limitation of resources. No one approach will satisfy the needs of all. CMSO looks forward to participating in the debate, driving improvement and ultimately ensuring a system that works for America's most vulnerable populations.